



Section 1A. TYPE OF LICENSE

Osteopathy and Surgery (DO)

Gender

Section 3. PREVIOUS NAMES

If your name has changed at any point you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by:	Marriage	Divorce	Court Order	Spouse Death Certificate
First Name	MI	Last Name	Suffix (Jr, Sr, etc.)	
Changed to current name by:	Marriage	Divorce	Court Order	Spouse Death Certificate
First Name	MI	Last Name	Suffix (Jr, Sr, etc.)	
Changed to current name by:	Marriage	Divorce	Court Order	Spouse Death Certificate
First Name	MI	Last Name	Suffix (Jr, Sr, etc.)	
Changed to current name by:	Marriage	Divorce	Court Order	Spouse Death Certificate
First Name	MI	Last Name	Suffix (Jr, Sr, etc.)	

Section 4A. HOME ADDRESS

Apartment	Suite	Floor	Number
Street Address 1			
Street Address 2			
City			
State	Zip Code + 4		
Phone	Fax	Email	

Section 4B. BUSINESS ADDRESS

Company Name _____

Apartment	Suite	Floor	Number
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Street Address 1

Street Address 2

City

State Zip Code + 4

Phone _____ Fax _____ Email _____

Fax _____ Email _____

Email

Section 4C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by selecting the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license and on the website will be your business address.

Home

Business

Business

Section 5A. POST SECONDARY SCHOOLS ATTENDED

List all post secondary schools that you have attended, in reverse chronological order, beginning with the most recent. Please arrange for each school to forward an official transcript

[illegible]

Section 5B. MEDICAL/PROFESSIONAL TRAINING AND MEDICAL/PROFESSIONAL PRACTICE

List all experience since medical school graduation below. Include **letters** (no certificates) from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description" use the letter from the key below. List experience in reverse chronological order, beginning with the most recent. Please account for all time since medical school graduation. Use a separate sheet of paper if you need more space.

Organization/Institution	Start Date	End Date	Description (Use Key Below) *

*** TRAINING AND PRACTICE DESCRIPTIONS**

- A. Fellowship D. Apprenticeship G. Other (Attach a typed explanation on a separate sheet of paper to this form.)
B. Internship E. Employment
C. Residency F. Private Practice

Section 5C. MEDICAL/PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

Are you now or have you ever been licensed in DC or any other state/jurisdiction?

Yes No

If "Yes" please complete section 5C of this form. You must request verification of licensure for all of these licenses, past and/or present.

Jurisdiction	Date License Was First Obtained	Description (Use Key Below) *

*** TRAINING AND PRACTICE DESCRIPTIONS**

- A. Fellowship D. Apprenticeship G. Other (Attach a typed explanation on a separate sheet of paper.)
B. Internship E. Employment
C. Residency F. Private Practice

Section 6. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included in this package or requested to be sent to the Board of Medicine. Keep a photocopy of all supporting documents for your records.

**HPLA
ONLY**

A.	Two recent passport type photos of the applicant's face (approx. 1" X 1") with applicant's name printed on the back. Home snapshots or digital photographs are not acceptable.	Yes No	
B.	Three (3) character reference forms.	Yes No	
C.	American Medical Association Profile.	Yes No	
D.	Verification(s) of licensure - These should be provided in a sealed envelope from the issuing jurisdiction for each license identified in Section 5C.	Yes No	
E.	All undergraduate, graduate, medical, and professional school transcripts. These transcripts should be provided in a sealed envelope from the issuing institution for each of the schools that you attended and listed in Section 5A.	Yes No	
F.	Documentation of all experience following graduation from medical school. Proof of experience should be submitted as a letter from the overseeing institution/organization.	Yes No	
G.	Examination scores - These should be provided in a sealed envelope from the examination contractor or administrator.	Yes No	
H.	Educational Commission for Foreign Medical Graduates (ECFMG) Certificate or Fifth Pathway Certificate (if foreign medical school graduate).	Yes No	
I.	Eminence application package (if Eminence 1 or 2 applicant)	Yes No	

Section 7. QUESTIONS**Applicants MUST answer all of the following questions**

Please answer questions A through K by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through K below, you must provide full information and complete details on a separate sheet of paper, including copies of all relevant court documents, and attach to this form.

A.	<p><u>Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.</u></p> <p>Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke the license or permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to DC Official Code § 47-2864 (2001).</p> <p>IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.</p> <p>As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia government as a result of any of the following:</p> <p>Fines, penalties, or interest assessed pursuant to DC Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985)</p> <p>Fines or interest assessed pursuant to DC Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994)</p> <p>Fines, penalties, or interest assessed pursuant to DC Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985)</p> <p>Past due taxes</p> <p>Past due District of Columbia Water and Sewer Authority service fees</p> <p>Fines or penalties assessed pursuant to DC Official Code Title 50, Chapter 23 (Traffic Adjudication)</p> <p>The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).</p>	Yes No	HPLA ONLY
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B.	Have you ever been convicted of or investigated for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	Yes No	
C.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	Yes No	
D.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	Yes No	
E.	Has any authority taken adverse action against your medicine/osteopathy license or privileges or informed you of any pending charges not previously reported to this Board?	Yes No	
F.	Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	Yes No	
G.	Have you ever been terminated from or resigned from a clinical or professional training program?	Yes No	
H.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	Yes No	
I.	Within the last ten (10) years, have you been treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	Yes No	
J.	(1) Have you withdrawn an application (in DC or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	Yes No	
K.	Have you ever been terminated due to practice issues or behavioral issues since obtaining your (professional) license within the last ten (10) years?	Yes No	
M.	MD's only – If your practice is limited to a specialty, please view the list below and enter a code for the appropriate specialty.	Code	
N.	MD's Only – If you are certified by the "American Board of" any specialty, please view the list below and enter a code for your certifying board.	Code	

SPECIALTIES

AD Administrative Medicine	NE Neurological Surgery	PH Physical Medicine & Rehabilitation
AL Allergy & Immunology	NU Nuclear Medicine	PL Plastic Surgery
AN Anesthesiology	OB Obstetrics & Gynecology	PR Preventive Medicine/Public Health
CO Colon & Rectal Surgery	OP Ophthalmology	PS Psychiatry & Neurology
DE Dermatology	OR Orthopedic Surgery	RA Radiology
EM Emergency Medicine	OT Otolaryngology	SU Surgery
FA Family Practice	PA Pathology	TH Thoracic Surgery
IN Internal Medicine	PE Pediatrics	UR Urology
MG Medical Genetics		

Section 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT SIGNATURE

NAME (please print)

DATE

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ONLY**

To report waste, fraud, or abuse by any DC government office or official, call the DC Inspector General at 1-(800)-521-1639.